REQUEST FOR REINSTATEMENT FORM

BROUGHT TO YOU BY THE Sanlam GROUP

Medical questionnaire application to be completed (this is dependent on your policy's terms and conditions).

A. POLICYHOLDER'S DETAILS

Policy Number .....

Surname ..... Title and Initials .....

Full Names ..... Contact Number .....

ID / Passport Number ..... Date of Birth (yyyy/mm/dd) .....

Email Address ..... Postal Address.....

..... Postal Code .....

B. PREMIUM PAYMENT DETAILS (only choose one)

Option A – Debit my Bank Account

Account Holder .....

Bank Name and Branch .....

Account Number ..... Branch Code .....

Type of Account ..... Deduction Date .....

Expiry Details (only applicable to credit card deduction requests).....

Option B – Stop Order Deduction

Employee Number ..... Facility Code .....

Employer's Name .....

I, ... hereby request that my policy premium be deducted from the above account/salary. I understand this premium will automatically increase in terms of the policy conditions on each anniversary unless such increase is cancelled or deferred by me in writing.

....

SIGNATURE OF PREMIUM PAYER DATE

C. DECLARATION BY POLICYHOLDER

I, the undersigned hereby acknowledge that I understand the content contained herein and confirm that the above information is true and correct in every detail and that Sanlam Developing Markets Limited is hereby authorised to update and amend my personal details.

....

SIGNATURE OF POLICYHOLDER DATE

CONTACT US

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